		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027433

Facility Name: Manorcare at Arlington Heights

Address: 715 West Central Rd. (Number) Arlington Heights (City) 60005 (Zip Code)

County: Cook

Telephone Number: (708) 392-2020 **Fax #** (708) 392-3250

IDPA ID Number: 520886946001

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/00 to 05/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	151	Skilled (SNF)	151	55,115	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	151	TOTALS	151	55,115	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,562	1,731	15,002	18,295	8
9	SNF/PED					9
10	ICF	8,783	20,730	1,795	31,308	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,345	22,461	16,797	49,603	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.00%

D. How many bed-hold days during this year were paid by Public Aid?
30 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 9,941

Medicare Intermediary BCBS Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/01 Fiscal Year: 05/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	399,294	27,732	4,516	431,542	2,493	434,035		434,035			1
2	Food Purchase		206,774		206,774		206,774	(1,865)	204,909			2
3	Housekeeping	171,141	21,017	2,551	194,709		194,709		194,709			3
4	Laundry	51,530	19,218	1,029	71,777		71,777	(30)	71,747			4
5	Heat and Other Utilities			170,696	170,696	11,430	182,126		182,126			5
6	Maintenance	59,701	8,621	48,290	116,612		116,612		116,612			6
7	Other (specify):*			1,810	1,810		1,810		1,810			7
8	**TOTAL General Services**	681,666	283,362	228,892	1,193,920	13,923	1,207,843	(1,895)	1,205,948			8
	B. Health Care and Programs											
9	Medical Director			33,421	33,421		33,421		33,421			9
10	Nursing and Medical Records	2,667,439	244,771	4,999	2,917,209	45,175	2,962,384		2,962,384			10
10a	Therapy	543,211	18,313	68,058	629,582		629,582		629,582			10a
11	Activities	59,698	3,194	1,540	64,432		64,432		64,432			11
12	Social Services	111,231		(11,398)	99,833		99,833		99,833			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,381,579	266,278	96,620	3,744,477	45,175	3,789,652		3,789,652			16
	C. General Administration											
17	Administrative	144,500		564,922	709,422	(162,435)	546,987		546,987			17
18	Directors Fees											18
19	Professional Services			16,282	16,282	(10,960)	5,322	(5,322)				19
20	Dues, Fees, Subscriptions & Promotions			80,670	80,670		80,670	(10,776)	69,894			20
21	Clerical & General Office Expenses	254,911	44,817	(27,464)	272,264	10,960	283,224	87,565	370,789			21
22	Employee Benefits & Payroll Taxes			698,594	698,594	(23,907)	674,687		674,687			22
23	Inservice Training & Education			1,092	1,092		1,092		1,092			23
24	Travel and Seminar			6,284	6,284		6,284		6,284			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,313	45,313		45,313		45,313			26
27	Other (specify):*											27
28	**TOTAL General Administration**	399,411	44,817	1,385,693	1,829,921	(186,342)	1,643,579	71,467	1,715,046			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,462,656	594,457	1,711,205	6,768,318	(127,244)	6,641,074	69,572	6,710,646			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Arlington Heights #0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			344,953	344,953	61,856	406,809		406,809			30
31	Amortization of Pre-Op. & Org.			28,432	28,432		28,432		28,432			31
32	Interest			26,529	26,529	65,388	91,917	(400)	91,517			32
33	Real Estate Taxes			330,254	330,254		330,254		330,254			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			104,599	104,599		104,599		104,599			35
36	Other (specify):*											36
37	**TOTAL Ownership**			834,767	834,767	127,244	962,011	(400)	961,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		405,582	52,330	457,912		457,912		457,912			39
40	Barber and Beauty Shops			21,911	21,911		21,911		21,911			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,673	82,673		82,673		82,673			42
43	Other (specify):*		225,334		225,334		225,334		225,334			43
44	**TOTAL Special Cost Centers**		630,916	156,914	787,830		787,830		787,830			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,462,656	1,225,373	2,702,886	8,390,915		8,390,915	69,172	8,460,087			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,865)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,492)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(30)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(400)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,897)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,407)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(435)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,322)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	109,796	21		24
25	Fund Raising, Advertising and Promotional	(10,776)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 69,172		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 69,172		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Arlington Heights

ID# **0027433**

Report Period Beginning: **06/01/00**

Ending: **05/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,865)	0	0	0	0	0	0	0	0	0	0	(1,865)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(30)	0	0	0	0	0	0	0	0	0	0	(30)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,895)	0	0	0	0	0	0	0	0	0	0	(1,895)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,322)	0	0	0	0	0	0	0	0	0	0	(5,322)	19
20	Fees, Subscriptions & Promotions	(10,776)	0	0	0	0	0	0	0	0	0	0	(10,776)	20
21	Clerical & General Office Expenses	87,565	0	0	0	0	0	0	0	0	0	0	87,565	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	71,467	0	0	0	0	0	0	0	0	0	0	71,467	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	69,572	0	0	0	0	0	0	0	0	0	0	69,572	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Arlington Heights** **#** **0027433** **Report Period Beginning:** **06/01/00** **Ending:** **05/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(400)	0	0	0	0	0	0	0	0	0	0	(400)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(400)	0	0	0	0	0	0	0	0	0	0	(400)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	69,172	0	0	0	0	0	0	0	0	0	0	69,172	45

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 564,922	HCR Manor Care Inc.	100.00%	$ 564,922	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	49,500	Heartland Management Services	100.00%	49,500		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 614,422			$ 614,422	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 33 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	671,002	407,536	7,678,747	2,493	2
3	5	Utilities - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	262,823		7,678,747	1,111	3
4	5	Utilities - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	2,777,349		7,678,747	10,319	4
5	10	Nursing - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	6,096,791	4,282,378	7,678,747	25,775	5
6	10	Nursing - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	5,221,432	3,383,186	7,678,747	19,400	6
7	17	General & Admin. - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	23,025,730	19,694,773	7,678,747	97,345	7
8	17	General & Admin. - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	82,128,599	31,955,235	7,678,747	305,142	8
9	22	Employee Benefits - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	2,724,065		7,678,747	11,516	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	(9,534,453)		7,678,747	(35,423)	10
11	30	Depreciation - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	74,480		7,678,747	315	11
12	30	Depreciation - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	16,563,680		7,678,747	61,541	12
13										13
14	32	Interest		0		14,161,817			65,388	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 144,173,315	$ 59,723,108		$ 564,922	25

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 849,637	$ 849,637			$ 65,388	1
2	Northwest Community						895,532	116,793			10,653	2
3	Debt Discount						(52,785)	(36,908)			15,876	3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(400)	8
9	TOTAL Facility Related						$ 1,692,384	$ 929,522			$ 91,517	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,692,384	$ 929,522			$ 91,517	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Manorcare at Arlington Heights **#** 0027433 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	312,842	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	312,842	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	330,254	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	330,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	316,896	8
1997	326,711	9
1998	331,619	10
1999	312,842	11
2000	330,254	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Arlington Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027433

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-04-100-008-0000	See Attached	$ 180,799.95	$ 180,799.95
2.	08-09-101-011-0000	See Attached	$ 149,453.59	$ 149,453.59
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 330,253.54	$ 330,253.54

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,403 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1973	$ 111,118	1
2					2
3	TOTALS			$ 111,118	3

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	151		1973	1969	$ 2,165,884	$ 75,643		$ 75,643	$	$ 1,894,359	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					165,950		165,950		1,195,497	9
10				1976	8,839						10
11				1978	23,518						11
12				1979	43,635						12
13				1980	3,940						13
14				1981	30,085						14
15				1982	90,702						15
16				1984	63,182						16
17				1985	24,863						17
18				1986	19,944						18
19				1987	105,148						19
20				1988	23,991						20
21				1989	51,409						21
22				1990	58,556						22
23				1991	222,698						23
24				1992	767,104						24
25				1993	52,576						25
26				1994	623,228						26
27				1995	44,468						27
28	UPGRADE LAUNDRY ROOM, STAIRWELL & SHOWER			1996	2,927						28
29	TILE			1996	12,870						29
30	INSTALL BASE COVE / REPLACE CEILING TILE			1996	7,736						30
31	REPLACE ROOF FAN			1996	1,370						31
32	CAPITALIZED LABOR-LAUNDRY RM UPGRADE			1996	7,272						32
33	TOILETS / PLUMBING			1996	2,194						33
34	ELECTRICAL WORK			1996	1,315						34
35	WALLVINYL			1996	1,281						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GAZEBO	1996	$ 2,014	$		$	$	$	37
38	SPRINKLER SYSTEM	1996	3,035						38
39	WALLCOVERINGS	1996	6,966						39
40	INSTALL ROOFTOP CHILLER	1996	15,766						40
41	FLOOR TILE & INSTALLATION	1996	24,364						41
42	NURSE STATION RENOVATION	1996	20,477						42
43	WALK-IN COOLER & INSTALLATION	1996	19,089						43
44	RENOVATE BATHROOM	1996	11,624						44
45	INSTALL SHELVING	1996	2,931						45
46	A/C REPAIR	1996	1,891						46
47	PIPING - LAUNDRY ROOM	1996	2,013						47
48	CARPETING	1996	7,261						48
49	BATHROOM RENOVATIONS	1996	7,896						49
50	CORPORATE OVERHEAD-NURSES STATION REN	1997	10,516						50
51	INSTALL CARPET	1997	3,794						51
52	INSTALL CABINETS / COUNTERTOPS / DOORS	1997	3,964						52
53	NURSES STATION RENOVATION	1997	6,871						53
54	REPLACE WATER LINE	1997	1,743						54
55	NURSES CALL SYSTEM	1997	23,581						55
56	INSTALL CEILING TILE	1997	7,443						56
57	HVAC	1997	15,227						57
58	POWER GENERATOR	1997	3,088						58
59	RETIREMENTS	1987	(62,983)						59
60	RETIREMENTS	1992	(18,208)						60
61	GENERATOR / SWITCHGEAR	1997	33,312						61
62	WALLCOVERINGS	1997	2,460						62
63	INSTALL CABINETRY	1997	8,800						63
64	REMOVE & INSTALL FENCE	1997	5,250						64
65	REFRIGERATOR / FREEZER REPAIRS	1997	2,830						65
66	FACILITY PLAN ALLOC-NURSES STATION REN	1997	5,965						66
67	REAR EXIT FRAME & DOOR	1997	2,761						67
68	ELECTRICAL	1997	12,876						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,655,352	$ 241,593		$ 241,593	$	$ 3,089,856	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,655,352	$ 241,593		$ 241,593	$	$ 3,089,856	1
2	SIDELIGHT FRAME & DOOR	1997	6,005						2
3	SHOWER ROOM REHAB	1997	16,502						3
4	FRENCH DOORS	1997	4,230						4
5	LIGHTING	1997	4,323						5
6	INSTALL SHOWER / FAUCET	1997	2,600						6
7	KITCHEN WORK	1997	4,960						7
8	HVAC / DUCTWORK	1997	6,590						8
9	SPRINKLER SYSTEM	1997	22,285						9
10	DRYWALL REPAIRS	1997	4,257						10
11	BOND COPIES	1997	316						11
12	EXTERIOR LIGHTING	1997	18,355						12
13	INSTALL CEILING TILE	1997	15,372						13
14	CARPENTRY	1998	9,278						14
15	DOORS / WINDOWS	1998	8,177						15
16	PLUMBING	1998	18,843						16
17	PAINTING / WALLCOVERINGS	1998	61,387						17
18	CASEWORK	1998	7,069						18
19	CEILING / FLOORING	1998	7,397						19
20	DRYWALL / FINISH STUD	1998	13,861						20
21	CORPORATE OVERHEAD	1998	1,651						21
22	DEVELOPER COSTS	1998	2,153						22
23	GENERAL CONTRACTOR FEES	1998	7,789						23
24	ROOFING / SOFFIT REPAIRS	1998	932						24
25	EXTERIOR SIGN WORK	1998	1,040						25
26	PAINTING/WALLCOVERING	1998	1,526						26
27	PLUMBING	1998	9,100						27
28	ELECTRICAL	1998	16,773						28
29	DEVELOPERS	1998	5,555						29
30	FLOORING/CEILING	1998	45,000						30
31	HVAC	1998	5,885						31
32	DOOR/WINDOWS	1998	5,542						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,990,105	$ 241,593		$ 241,593	$	$ 3,089,856	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,990,105	$ 241,593		$ 241,593	$	$ 3,089,856	1
2	SIGN	1998	11,862						2
3	PLUMBING	1999	2,482						3
4	FLOORING/CEILING	1999	25,000						4
5	LIGHT FIXTURE	1999	2,990						5
6	HVAC	1999	3,230						6
7	ENGINEER FEES, EXPENSES LOUNGE RENOV	1999	998						7
8	NEW DOOR, KICKPLATE, HANDLES	1999	3,071						8
9	WALLCOVERING	1999	360						9
10	WALLCOVERING	1999	121						10
11	ADJ CONST COST FOR RETENTION	1999	(11,545)						11
12	VINYL WALLCOVERING	1999	495						12
13	VINYLIZED FABRIC	1999	68						13
14	WALLCOVERING	1999	459						14
15	COLD WATER PIPES	1999	2,412						15
16	WALLCOVERING	1999	2,296						16
17	WALLCOVERING	1999	112						17
18	CARPET	1999	3,833						18
19	DINING HVAC	1999	2,611						19
20	CABINETS	2000	6,835						20
21	WALCOVERING & FLOORING	1999	10,131						21
22	WALLCOVERING	1999	300						22
23	MJ ROST FREIGHT	2000	81						23
24	MED ROOM REMODEL	2000	11,690						24
25	MJ ROST FREIGHT (CARPET)	2000	128						25
26	LOBBY, RSTROOM, & DINING DECORATIONS	2000	2,215						26
27	FLOORING	2000	1,280						27
28	PAINTING & CERAMIC TILE INSTALLATION	2000	2,114						28
29	VWC REPAIR/VCT	1999	985						29
30	LOUNGE & DINING RENOVATION	2000	2,801						30
31	LOUNGE & DINING HVAC ADDTL COST	2000	116						31
32	WALLCOVERING	2000	125						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,079,761	$ 241,593		$ 241,593	$	$ 3,089,856	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,079,761	$ 241,593		$ 241,593	$	$ 3,089,856	1
2	WILLIAMSBURG LOUNGE & DINING RENOVATION	2000	3,255						2
3	WALLCOVERING FOR WILLIAMSBURG DINING	2000	374						3
4	ADDTL RENOVATION COST/WILLIAMSBRG DINING	2000	193						4
5	ROOF REPAIRS	2000	1,520						5
6	DOOR	2000	790						6
7	DRYWALL - SITE SURVEY RENO	2000	368						7
8	AIR CONDITION	2000	37,650						8
9	ADJ CONST COST FOR RETENTION	2000	11,545						9
10	COMMUNICATION SYSTEM	2000	2,644						10
11	INSTALLATION - CARPET	2000	4,217						11
12	SIT SURVEY RENO	2000	483						12
13	ELECTRICAL - BREAKER REPLACEMENT	2000	2,370						13
14	CARPET - RESIDENT RM	2000	1,035						14
15	MJ ROST - CARPET	2000	147						15
16	CARPET	2000	878						16
17	AWNING	2000	2,350						17
18	CERAMIC TILE - BATH RENO	2000	19,688						18
19	SLIDING DOORS	2000	9,420						19
20	FRONT ENT DOORS	2000	4,685						20
21	A/C UNITS - ROOFTOP	2000	806						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,184,179	$ 241,593		$ 241,593	$	$ 3,089,856	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,154,224	$ 103,360	$ 103,360	$		$ 799,501	71
72	Current Year Purchases	35,298						72
73	Fully Depreciated Assets							73
74	H/O Office			61,856	61,856			74
75	TOTALS	$ 1,189,522	$ 103,360	$ 165,216	$ 61,856		$ 799,501	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,484,819	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 344,953	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 406,809	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 61,856	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,889,357	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 104,599 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	7744 hrs	$ 165,961	878	$ 18,810	$ 3,495	8,622	$ 188,266	1
2	Licensed Speech and Language Development Therapist	10a	2194 hrs	47,014	1,166	24,993	396	3,360	72,403	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	15410 hrs	330,236	1,132	24,255	1,130	16,542	355,621	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				405,582		405,582	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/Spharm,Podiatry	39,3				52,330	13,292		65,622	13
14	TOTAL			$ 543,211	3,176	$ 120,388	$ 423,895	28,524	$ 1,087,494	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 137,492	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (330,498))	1,510,240		3
4	Supply Inventory (priced at)	10,720		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,329		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,662,781	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,118		13
14	Buildings, at Historical Cost	5,184,179		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,189,522		16
17	Accumulated Depreciation (book methods)	(3,889,357)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	250		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,595,712	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,258,493	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,540	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	473,304		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	330,254		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	199,951		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,021,049	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	79,885		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 79,885	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,100,934	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,157,559	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,258,493	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,641,073	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,641,073	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,586,162	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,586,162	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,069,676)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,069,676)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,157,559	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,171,148	1
2	Discounts and Allowances for all Levels	(1,670,668)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,500,480	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,999,094	6
7	Oxygen	(1,521)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,997,573	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,407	12
13	Barber and Beauty Care	18,710	13
14	Non-Patient Meals	1,865	14
15	Telephone, Television and Radio	7,492	15
16	Rental of Facility Space		16
17	Sale of Drugs	390,148	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,506	19
20	Radiology and X-Ray		20
21	Other Medical Services	686	21
22	Laundry	30	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 477,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,180	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,180	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,977,077	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,193,920	31
32	Health Care	3,744,477	32
33	General Administration	1,829,921	33
	B. Capital Expense		
34	Ownership	834,767	34
	C. Ancillary Expense		
35	Special Cost Centers	787,830	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,390,915	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,586,162	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,586,162	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,990	3,341	$ 100,972	$ 30.22	1
2	Assistant Director of Nursing	652	728	19,559	26.87	2
3	Registered Nurses	43,419	48,513	887,749	18.30	3
4	Licensed Practical Nurses	21,622	24,158	382,233	15.82	4
5	Nurse Aides & Orderlies	112,371	125,553	1,232,866	9.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	20,402	22,756	487,596	21.43	7
8	Rehab/Therapy Aides	4,426	4,936	55,615	11.27	8
9	Activity Director	5,343	5,964	59,698	10.01	9
10	Activity Assistants					10
11	Social Service Workers	5,262	5,870	111,231	18.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,264	34,929	399,294	11.43	15
16	Dishwashers					16
17	Maintenance Workers	3,863	4,317	59,701	13.83	17
18	Housekeepers	16,098	17,979	171,141	9.52	18
19	Laundry	4,718	5,271	51,530	9.78	19
20	Administrator	2,822	2,080	144,500	69.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,257	15,257	254,911	16.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,944	3,285	44,060	13.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	293,453	324,937	$ 4,462,656 *	$ 13.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 3,731	5,1,3	35
36	Medical Director	Monthly	33,421	5,9,3	36
37	Medical Records Consultant	Monthly	2,350	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,540	5,11,3	44
45	Social Service Consultant				45
46	Other(specify) Physician	Monthly	4,000	5,10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,042		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	56	546	5,10,3	52
53	TOTAL (lines 50 - 52)	56	$ 546		53

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Smelser	Administrator	0	$ 144,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,500

B. Administrative - Other

Description	Amount
Management Fees	$ 564,922
TOTAL (agree to Schedule V, line 17, col. 3)	$ 564,922
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 5,322
Carol Gawron	Special Consulting	7,273
Corporate Intelligence	Special Consulting	2,687
Retzke & Assoc. Inc.	Special Consulting	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,282

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,678
Unemployment Compensation Insurance	29,191
FICA Taxes	319,562
Employee Health Insurance	233,168
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	1,542
Payroll Overhead Allocated	1
401K / SMSP Match	37,450
Other Employee Benefits	39,079
Tuition Program	1,878
Employee Uniforms	(4,955)
Home Office Allocation	(23,907)
TOTAL (agree to Schedule V, line 22, col.8)	$ 674,687

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,280
Advertising: Employee Recruitment	43,756
Health Care Worker Background Check	
(Indicate # of checks performed 52)	1,049
Dues & Subscriptions	3,299
Association Dues	5,938
Public Relations	1,590
Marketing	258
Advertising	23,500
Less: Public Relations Expense	(1,590)
Non-allowable advertising	(9,186)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,894

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,708
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Auto Expense	1,576
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,284

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 5938**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **58,134** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,673**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,865)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.